MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

REPORT OF SERIOUS INJURY REFERRAL FORM

Please complete this form for an injured worker that you feel may qualify as seriously injured as defined in the Statement of Policy – Eligibility Guidelines for Second Injury Fund rehabilitation benefits.

Complete to the best of your knowledge.

Injured Worker: _____

Address: _____

Date of Injury: _____ SSN: _____

Employer: _____

Address: _____

Treating Physician: _____

Address: _____

Facility Name: _____

Address: _____

Name of Person Referring: _____

Phone Number: _____

Date Treatment Began: _____ Date Treatment Ended *(if completed):* _____

Return completed form to:

Fax: 573-522-1623

Phone: 573-526-3876

Mail: Attn: Rhonda Forck
Missouri Division of Workers' Compensation
P. O. Box 58
Jefferson City, Missouri 65102-0058